US Department of Health and Human Services
Public Health Service
Indian Health Service

IHS Integrated Diabetes Education Recognition Program
Sample Diabetes Educational Needs Assessment

Date of Diagnosis: ____/____/____

FAMILY MEMBERS WITH DIABETES:

☐Parents ☐Brother/Sister ☐Grandparents ☐Aunts/Uncles ☐Grandchildren ☐Children

Other MedicalProblems: _____

_____

How long have you had diabetes? _____

Have you ever been in the hospital for diabetes?

☐Yes ☐No If yes, when?

_____

Have you ever received any diabetes teaching?

☐Yes ☐No

Explain Diabetes in your own words:

I. CULTURAL FACTORS/Health Beliefs

Any foods you do not eat: _____

Religious observances: _____

Other: _____

The hardest thing about diabetes is: _____

What would help you live better with diabetes? _____

Do you feel your health is: ☐Poor ☐Good ☐Excellent

How do you feel about your weight? _____

Do you feel diabetes can be prevented? ☐Yes ☐No

Do you believe your religious spiritual beliefs affect your health? ☐Yes ☐No

Do you believe that no matter what you do, if you are going to get sick you will? ☐Yes ☐No

I. NUTRITION

Who does most of the cooking in your home? _____ Do you follow a meal plan? ☐Yes ☐No
If yes, explain: _____

Have you met with a dietician? ☐Yes ☐No Have you had a diabetes diet? ☐Yes ☐No
Who provided that diet instruction? _____
What time do you usually eat your meals? Morning: _____ Afternoon: _____ Evening: _____

Do you eat snacks? ☐Yes ☐No When? _____
How often do you eat away from home? _____

Do you drink alcohol? ☐Yes ☐No

II. MONITORING – Blood Sugar Testing

I bring my blood sugar machine to clinic visits: ☐Yes ☐No

I bring my blood sugar logbook to clinic visits: ☐Yes ☐No
What type of floccose monitor do you have? _____

When was the last time you checked your blood sugar? _____

How often do you test your blood glucose? _____

What are the usual home blood sugar results? _____

What do you consider a normal glucose level? _____

III. HYPOGLYCEMIA/HYPERGLYSCEMIA "Low Blood Sugar"

Do you wear or carry diabetes identification with you at all times? ☐Yes ☐No

Do you carry diabetes medication with you when you are away from home? ☐Yes ☐No
How do you feel when you have *low* blood sugar? _____

What causes *high* blood sugar? _____

What do you do for *high* blood sugar? _____

IV. MEDICATION

Medication: _____ Dose: _____ Time/s Taken: _____
Medication: _____ Dose: _____ Time/s Taken: _____
Medication: _____ Dose: _____ Time/s Taken: _____

Do you ever miss taking your medication? ☐Yes ☐No

Do you ever take extra medication? ☐Yes ☐No When? _____

Do you take your diabetes medication when you are sick? ☐Yes ☐No
What non-diabetes medication, over the counter medications, vitamins/herb supplements do you take?

V. COMPLICATIONS

Do you have any of these complications? (check all that apply & date it started)

☐Retinopathy (eye disease)___/___/___ ☐Foot Problems___/___/___☐Heart Problems___/___/___

☐Neuropathy (numbness)___/___/___ ☐Nephropathy (kidney disease)___/___/___

☐Sexual Problems___/___/___☐High blood pressure___/___/___☐Depression___/___/___

VI. LIFESTYLE/EXERCISE

How many people live in your home? _____How many have diabetes? _____

Do you? ☐Work or ☐Go to school?
How many hours do you work? _____Go to school? _____
Who can help you with your diabetic care?
_____

Do you get any exercise other than the usual days routine? ☐Yes ☐No
If so, what kind? _____

Do you use tobacco? ☐Yes ☐No
When was the last eye exam? _____

Do you check your feet? ☐Yes ☐No How often? _____
When was your last visit to the dentist (date)? ___/___/___

VII. FACTORS INFLUENCING EDUCATION & LEARNING

(Check Yes or No and explain if needed)

Vision problems ☐Yes ☐No ☐Reading ☐Listening

Hearing problems ☐Yes ☐No ☐Doing Things ☐With a group

Mobility problems ☐Yes ☐No ☐Slides/Movies ☐Talking/Asking questions

Loss of sensation ☐Yes ☐No ☐One on one ☐Have someone show you

Complication ☐Yes ☐No

Speak other than English? ☐Yes ☐No

VIII. LEARNING ENHANCERS

☐appears eager ☐is able to participate in education ☐can write

☐can read ☐has general knowledge regarding diabetes ☐family reinforces teaching

☐is forgetful ☐written material is available ☐Other

IX. LEARNING BARRIERS

☐blindness ☐is anxious ☐impaired manual dexterity ☐hard of hearing

☐neurological defect ☐is forgetful ☐decreased motivation to learn ☐can write

☐decreased attention span ☐learning need ☐none ☐other

X. READINESS FOR BEHAVIOR CHANGE

Making Changes	Haven't thought about	Thinking about	Planning	Doing	Off & On
Diet-Meal Patterns					
High Fiber					
Low Fats					
Portion Size					
Exercise					
Check blood sugar					
Recording					
Stop smoking					

XI. PREGNANCY

Are you pregnant now? ☐Yes ☐No Do you plan on having children in the future? ☐Yes ☐No

Due Date:____/____/____

Have you had gestational diabetes? ☐Yes ☐No

If yes, when?

XII. CURRICULUM

Check the topics you feel you need to learn more about so you can control your diabetes:

☐What is Diabetes?	☐Low Blood Sugar	☐Neuropathy (Nerve Disease)
☐Feelings about having Diabetes	☐High Blood Sugar	☐Illness
☐Coping with Diabetes at home	☐High Blood Pressure	☐Heart Problems
☐Nutrition	☐Monitoring Blood Glucose	☐Smoking
☐Exercise	☐Retinopathy (Eye Disease)	☐Complications
☐Medications	☐Peridontal (Tooth Disease)	☐Sexual Problems
☐Diabetes & Pregnancy	☐Other	

Signature: _____

Reviewed and complete: _____ **Date:** _____

INSTRUCTIONS:
The Diabetes Patient Education Needs Assessment form (IHS-504) will be filed in the "Diabetes" section (IHS-677-1) of the patient's chart. Both the health care providers and/or the patient can fill out this assessment form. The assessment form can be completed during one clinic visit or over a period of several clinic visits. The needs assessment should be updated yearly or as needed.

Patient Identification

3/2002

Source: IHS Integrated Diabetes Education Recognition Program Sample Materials

IHS Integrated Diabetes Education Recognition Program
Sample Educational Needs Assessment

Interviewer: _____ Date: _____

Diabetes History

Are there any family members that have diabetes?

☐Father ☐Mother ☐Siblings ☐Grandparents ☐None

Comments: _____

_____

Type of Diabetes:

☐Type 2 ☐Type 1 ☐GDM ☐ PGDM ☐IGT

Date of Diagnosis: ___/___/___ Where? _____

Do you have any health problems because of your diabetes? ☐Yes ☐No

Comments: _____

Have you seen a dietician? ☐Yes ☐No

If yes, where? _____

Blood glucose monitoring? ☐Yes ☐No Name of Meter: _____

How often do you test? _____ What time of day? _____a.m./p.m.

Hemoblobin A1c _____ Date: ___/___/___

Medical History

Do you have any of the following:

☐No problems ☐High BP ☐High cholesterol ☐Heart disease ☐Eye problems ☐Kidney problems

☐Foot Problems ☐Other: _____

What kind of medication do you take for this?

Name: _____ Dose: _____ Time Taken: _____a.m./p.m.

Name: _____ Dose: _____ Time Taken: _____a.m./p.m.

Name: _____ Dose: _____ Time Taken: _____a.m./p.m.

Any surgeries? _____

Known allergies (medicine/food)? _____

Weight change history: _____

Women: G___P___LC___AB___Last Pap smear: _____

Birth Control Method: _____

Method of Treatment

Eating Habits:

Are you eating differently since you found out you have diabetes? ☐Yes ☐No

If yes, what types of changes have you made?

☐Eat Less ☐Eat less fat ☐Eat more vegetables ☐Drink less pop, juice

☐Other:_____

How many times a day do you eat?

☐1 ☐2 ☐3☐Other:_____

Which meal(s) do you tend to skip? ☐Breakfast ☐Lunch ☐Dinner

Who does the cooking in your house? ☐Self ☐Spouse ☐Other

Who does the food shopping in your house? ☐Self ☐Spouse ☐Other

How often do you eat out?

_____

Addressograph

Exercise:

Type of exercise/activities: _____

How many times per week?_____

Hours TV/day:_____

Diabetes Medication:

Name: _____ Dose:_____ Time Taken:_____a.m./p.m.

Name: _____ Dose:_____ Time Taken:_____a.m./p.m.

Name: _____ Dose:_____ Time Taken:_____a.m./p.m.

Are you having problems with your diabetes medications? ☐Yes ☐No

Comments: _____

Any problems with: ☐Low blood sugar (<70)? ☐High blood sugar (>350)? ☐None

Risk Factors

Tobacco User? ☐Yes ☐No ☐Quit

Number of drinks/week? _____

Socio-Economic

Present/Previous Employment_____Work Hours_____

Financial Concerns? ☐Yes ☐No Number of years of school completed: _____

Possible barriers to learning: ☐Vision ☐Hearing ☐Reading ☐Language ☐Stress ☐Other: _____

Comments: _____

Support Systems

Marital Status ☐Single ☐ Married ☐Divorced ☐ Widowed ☐Other

# of people in household: _____ Primary support person: _____

Other support: _____

Cultural Factors

Tribal affiliation: _____

Tribal language spoken? ☐Yes ☐No
Comments: _____

Health Care Utilization

Last PCP Visit: _____ Primary Care Provider: _____
Eye Exam: _____ Foot Exam: _____
Dental Exam: _____ ER/Hospitalization: _____

Primary Language:

_____

Learning Preference (LP):
1. Talking & Asking 2. Videos 3. Small Group 4. Reading 5. Practicing & Doing
6. Other: _____

Special Practices/Limitations (SP/L): (check all that apply)
1. Cannot read English 2. Sensory deficits 3. Social Stresses 4. Interpreter needed 5. Physical limitations
6. Financial 7. Cognitive impairment 8. Emotional Stress 9. Cultural/religious 10. Other: _____

Readiness to Learn (RL):
1. Eager to learn 2. Receptive 3. Unreceptive 4. Communication barriers 5. Cognitive/Sensory Impairment
6. Fatigue/pain/illness 7. Other (specify): _____

Patient's Understanding/Response to Education (codes):
Good (G) – verbalized understanding. Demonstrates correctly. Verbalizes decision to change (plan of action indicated).
Fair (F) – verbalized need for more education. Undecided about making a decision or a change. Return demonstration indicates need for further education.
Poor (P) – Does not verbalize understanding. Refuses to make a decision or needed changes. Unable to return demonstration.
Refuses (R) – Refuses education.
Group (GP) – Education provided in group. Unable to evaluate response.

Date	LP Code	SP/L Code	RL Code	Information Obtained From	Comments	Assessment Completed By
				☐ Patient ☐ Other		
				☐ Patient ☐ Other		
				☐ Patient ☐ Other		
				☐ Patient ☐ Other		

Addressograph

Multidisciplinary
Patient & Family Education
Assessment Record
Ambulatory Care Department

Source: PIMC – 214
3/2001

Source: Phoenix Indian Medical Center (PIMC) DEPTH Program

IHS Integrated Diabetes Education Recognition Program
Sample Educational Needs Assessment
Diabetes Program Data Information Sheet

Please provide the following information for our files. This information will be used to provide care that best fits your needs. Our patient information files are kept confidential.

Name: _____ Chart#: _____ SS#: _____

Birthday: _____ Sex: M/F Tribe(s): _____ Degree Indian Blood: _____

Address: Street_____ Phone#: Home:(____)_____
City_____ Work: (____)_____
State: _____ Zip: _____ Date of Diagnosis:_____

Clinic where most of your
Health Care is received: _____ Primary Care Provider:_____
Payment Source: Indian Health Care: _____ Insurance:_____ Tribal Healthcare:_____
(Check all that apply) Medicare: _____ Medicaid: _____

How much do you know about diabetes and its care?

- I have never received any Information about diabetes. True False (If true, stop here)
- I have completed a course in Diabetes self-management. True False

a. The type of diabetes I have is: Type 1 Type 2
b. Type 2 diabetes is caused by: 1. The body not using insulin well.
2. The pancreas not making insulin.
c. In Type 2 diabetes 1. Improves the body's use of insulin.
Diet and exercise 1. Improves insulin production.

d. Normal blood sugar before Breakfast is 70-110 True False

Please check the columns that describe your knowledge about each area of diabetes.

Area of Knowledge	No information From any source	Information from: Reading, TV, friends or family	Information from: Clinic visit more Than 1 year ago	Information from: Clinic visit less Than 1 year ago
Diabetes in general				
Diet				
Exercise				
Home testing blood sugar				
Eye care				
Heart risks and diabetes				
Foot Care				
Nerve damage from diabetes				
Dental Care				
Diabetes medication				

DIABETES HEALTH ASSESSMENT

Please fill out the front and back of this form. Your answers will help guide your diabetes education to meet your individual needs.

My beliefs about my health and diabetes: Please circle one answer.

My health is: 1) Excellent 2) Good 3) Fair 4) Poor

I am concerned about my health: 1) A lot 2) Some 3) Hardly any 4) None

I have this much control over my future health: 1) A lot 2) Some 3) Hardly any 4) None

The changes I need to make to control my diabetes are: 1) Possible 2) Difficult 3) Too Difficult

I use traditional Indian ways to improve my health: 1) A lot 2) Some 3) Hardly any 4)Never

I use healing practices other than Indian medicine and medical care: 1) A lot 2) Some 3) Hardly any 4) None

Can diabetes cause kidney failure? 1) Yes 2) No

Will I have problems in completing my diabetes education or coming to clinic for care?

I travel this many miles to the clinic_____

How I get to clinic: 1) My family or friend drives me. 2) I drive myself. 3) I ride a van or bus.

I will have these problems in coming to my education or clinic visits.

1) I work nights 2) I have no sick leave 3) My boss will not like this 4) No problems

Other problems:

How well do my friends and family support my efforts to control my diabetes?

I have family and friends that I can ask to help me. 1) Yes 2) No
They live in my house or nearby. 1) Yes 2) No
Names and relationship of persons(s) who will help me with my diabetes:
My close family and friends want to learn about diabetes. 1) Yes 2) No
My close family and friends encourage me to do the things that improve my health. 1)Yes 2) No

How much stress do I feel and how well do I control it?

My stress level has been: (Low) 1 2 3 4 5 (high)
I eat or drink or smoke when I am stressed: 1) Yes 2) No 3) Sometimes
I exercise or do other helpful things to relieve stress: 1) Yes 2) No 3) Sometimes
What I do to relieve my stress works well: 1) Not at all 2) Now and Then 3) Sometimes 4) Usually

Rev. 11/98
CLA - 60 (A)

How do I feel about having diabetes?:

Since I was told I have diabetes, I find that I often feel: (You may circle more than one)

1) Shock 2) Guilty 3) Disbelief 4) Frustrated

5) Angry 6) Sad 7) No change 8) Accepting 9)Other

I think my family feels this way about my diabetes: (You may circle more than one)

1) Shock 2) Guilty 3) Disbelief 4) Frustrated

5) Angry 6) Sad 7) No change 8)Accepting 9) Other

Having diabetes is: 1) A disaster 2) A burden 3) A problem 4) A challenge 5) An opportunity

How I like to learn:

I like to learn in these ways:

1) Watching slides/movies 2) Reading 3) Others showing me how 4) Discussions

5) Listening to others 6) Using computers 7) Other_____

I like my diabetes education: 1) All at once 2) Over a few visits

I need someone to tell me what the information means in my native Indian language. 1)Yes 2) No

If "Yes"_____I can bring someone who speaks my language with me

_____I will need someone from the hospital staff to help.

How much confidence do I have in managing my diabetes?

I have confidence that I can make my own decisions about self care options.

(Very little) 1 2 3 4 5 (Quite a lot)

I have confidence that I can participate as an equal partner with the clinic staff in my diabetes care.

(Very little) 1 2 3 4 5 (Quite a lot)

I have confidence that I can make safe choices between self care or medical care.

(Very little) 1 2 3 4 5 (Quite a lot)

I have confidence that I can use health care services to meet my routine and urgent health needs.

(Very little) 1 2 3 4 5 (Quite a lot)

I have confidence that I can tell my doctor how my self care between visits affected my diabetes.

(Very little) 1 2 3 4 5 (Quite a lot)

I have confidence that I can find the strength within myself for being healthy.

(Very little) 1 2 3 4 5 (Quite a lot)

I have confidence that I can manage my diabetes so that I can do things I enjoy doing.

(Very little) 1 2 3 4 5 (Quite a lot)

I have confidence I can find ways to help me feel better when I feel upset about diabetes.

(Very little) 1 2 3 4 5 (Quite a lot)

Claremore Indian Hospital
Medical History - Type 2 Diabetes

Were your ever told you had borderline diabetes? Yes / No
When were you told you had diabetes? _____ Where were you? _____
Have you ever been in the hospital for diabetes? Yes / No
Did you have any of the following problems at the time you were told you had diabetes or in the weeks or months before: Please check.

_____Other illness	_____Leg cramps	_____Skin infection
_____Surgery	_____Problems seeing things	_____Yeast infections
_____Weight loss	_____Burning feet	_____Very thirsty
_____Weight gain	_____Passing lots of urine	_____Very tired

Do you have or have you had any of the following which tend to recur?

_____Blurred vision	_____Feeling of fullness	_____High cholesterol
_____Bleeding in eye	_____Vomiting	_____High triglycerides
_____Laser treatments	_____Diarrhea	_____Athletes' feet
_____Eye surgery	_____Constipation	_____Numb feet
_____Cataracts	_____Dizziness	_____Calluses
_____Glaucoma	_____Kidney infection	_____Corns
_____Blindness	_____Protein in urine	_____Slow healing wounds
_____High blood pressure	_____Leaking urine	_____ Thick or Ingrown nails
_____Poor circulation	_____Trouble with sex	_____ Joint Pain or Swelling
_____Shortness of Breath	_____One-sided weakness	_____Trouble sleeping

Do you have or have you had problems with the following:

_____Head	_____Thyroid	_____Kidneys/bladder
_____Eyes	_____Lungs	_____Prostate
_____Face	_____Heart	_____Female problems
_____Mouth	_____Breasts	_____Hips, Legs, Knees
_____Teeth/Gums	_____Stomach	_____Shoulder, Arms, Hands
_____Ears	_____Bowels	_____Feet
_____Throat	_____Gallbladder	_____Drug Allergies
_____Neck	_____Back	_____Other Allergies
_____Anemia	_____Tuberculosis	_____Emotional/Mental Illness
_____Skin	_____Epilepsy/Seizures	_____Liver/Hepatitis

At the time you were told you had diabetes how much did you weigh? _____
What was your weight at 18? _____ What is the heaviest you have been? _____ When? _____
How many brothers do you have? _____ How many are overweight? _____
How many sisters do you have? _____ How many are overweight? _____
How many children do you have? _____ How many are overweight? _____

Patient Identification:

Family History: Does any family member have diabetes? Please check.

Father _____	Mother _____	Spouse _____
Sister/Brother _____	Children _____	Aunt/Uncle (Father) _____
Grandparents (Father)_____	Grandparents (Mother)_____	Aunt/Uncle (Mother) _____

Diabetes Medicines:

Have you ever taken pills for diabetes? Yes / No

Name_____ Amount_____ Name _____Amount_____

Have you ever taken insulin for diabetes? Yes / No Kind_____

List all the medicines you take right now.

Name of Medicine	Number of Pills Each Dose	Number of Times Per Day

Other Health Risks:

How often do you drink alcoholic beverages such as beer, wine or liquor? Please circle:
1) 5-7 days/week 2) Weekends only 3) 1 time a month 4) Less than 3 times/year 5) None.

How much do you use tobacco? Cigarettes _____ Cigars or Pipe _____ Dip or Chew _____
If you have you quit smoking, how long has it been since you quit? _____

Health Care Use:

When you have a health problem, where do you usually go first? Please circle.
1) IHS clinic 2) IHS emergency room 3)Tribal clinic 4) Other_____

During the past year how many times did you see or speak to a medical doctor about your health in a clinic? _____

Education/Occupation:

Highest school grade completed: Please circle.
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

What is your present occupation?_____ What are your work hours?_____
How much physical activity does your job require? (Mostly sitting) 1 2 3 4 5 (Heavy labor)

For Women Only:

How many times have you been pregnant? _____ How many children have you had? _____
How many miscarriages have you had? _____
Did any of your babies weigh more than 9 pounds? Yes / No Less than 6 pounds? Yes / No
Did you ever have diabetes during pregnancy? Yes / No Do you still have periods? Yes / No
Do you use birth control? Yes / No If yes, What kind? _____

_____
Professional Signature